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Issue Date: 11 September 2007

In the Matter of

J.M., Jr.¹
Claimant

Case No.: 2004 BLA 5277

v.

HOLLY BETH COAL COMPANY, INC./
ROCKWOOD INSURANCE COMPANY.
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS

Party in Interest

Appearances: Mr. Ron Carson, Personal Representative
For the Claimant

Ms. Ann Musgrove, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER ON REMAND –
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. J.M. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

On June 7, 2005, based on my determination that Mr. M. had complicated pneumoconiosis, I concluded that he had established a change in a condition of entitlement

¹Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

previously adjudicated against him. Upon subsequent consideration of the entire record, I further concluded that Mr. M. was totally disabled due to coal worker's pneumoconiosis and accordingly awarded black lung disability benefits.

The Employer appealed the award of benefits. On May 25, 2006, the Benefits Review Board ("BRB" and "Board") determined that I made a significant error by finding that the preponderance chest x-rays positive for complicated pneumoconiosis and lacking affirmative evidence of an etiology other than pneumoconiosis. In particular, the Board stated that I "did not recognize that 'opacity' is a term of art used to classify pneumoconiosis" and consequently erred by concluding Dr. Scatarige, Dr. Hippensteel, and Dr. Wheeler diagnosed complicated pneumoconiosis, based on their findings of pulmonary opacities greater than one centimeter. As a result, the BRB vacated my award and remanded the case for further adjudication consistent with its determinations.²

Contrary to the Board's summarization and determination, I did not render a specific finding that Dr. Scatarige, Dr. Hippensteel, and Dr. Wheeler diagnosed complicated pneumoconiosis. Instead, I determined their radiographic interpretations helped establish the presence of large pulmonary opacities in Mr. M.'s lungs. Then, in accordance with *Director, OWCP v. Eastern Coal Corp [Scarboro]*, 220 F.3d 250 (4th Cir. 2000), I considered the diverse medical evidence on the etiology of these large pulmonary masses, including the opinions of Dr. Scatarige, Dr. Hippensteel, and Dr. Wheeler, and concluded the preponderance of the evidence, including biopsy assessments, did not affirmatively establish some cause for the large pulmonary opacities other than pneumoconiosis. Based on subsequent case law, my principal legal error occurred in requiring an affirmative showing of an alternative etiology. Nevertheless, during the adjudication of this remand, I will follow the Board's remand instructions, as well as the specific steps mandated by the BRB in a recent decision for the adjudication of complicated pneumoconiosis. See *Mullins v. Plowboy Coal Co.*, BRB No. 06-0900 (Aug. 30, 2007) (unpub.).

Procedural Background

In my June 7, 2005 decision, I previously summarized the procedural history of Mr. M.'s two claims, including the present claim he filed in April 2002. After the BRB's remand, on September 27, 2007, I provided the parties with an opportunity to submit briefs considering the issues on remand. On November 20, 2006, I received a remand brief from Employer's counsel.

REMAND ISSUES

1. Whether, in filing a subsequent claim on April 22, 2002, Mr. M. has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the final denial of his prior claim was based in March 2001.
2. If Mr. M. establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

²I received the case file for re-adjudication on August 31, 2006.

3. If Mr. M. is entitled to benefits under the Act, whether the onset of his total disability predated his employment with the Employer, Holly Beth Coal, Inc., precluding its liability as the responsible operator.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Mr. M., a widower, was born on July 11, 1931. He started working in the coal mines in August 1956 and worked until October 1986. Because of some brief periods where Mr. M. was off of work, his total length of coal mine employment is 28 $\frac{3}{4}$ years. Mr. M. left coal mining because of back problems and upon advice from his physician, Dr. Sutherland, that his health was worsening due to his breathing coal dust. In his last position as a coal miner, Mr. M. was a roof bolt helper, which required him to set steel jacks for the bolter. As part of his work, Mr. M. had to lift the jacks weighing up to fifteen pounds. Mr. M. was not able to stand because he worked in 28 to 32 inch high seams of coal and therefore his job required a lot of bending and crawling. He also pulled a wagon containing supplies that weighed at least 50 pounds. (TR, pages 25 to 31 and 36)

Mr. M. began experiencing breathing problems in 1972 or 1973 that presented as shortness of breath with exertion. Presently, he has difficulty climbing a set of stairs. Dr. Robinette treats Mr. M. with breathing pills to improve his condition. Mr. M. started smoking in 1950 or 1951 and stopped in 1968, smoking 9 cigars and 3 to 4 pipes of tobacco per day. Mr. M. started dipping tobacco in 1956 or 1957 and continues to dip with a box lasting him two days. Mr. M. has not been gainfully employed since working in the coal mines in 1986. (TR, pages 31, and 34 to 40)

Issue # 1 – Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied (“applicable condition of entitlement”) has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.³ Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.⁴ Third, the miner has to demonstrate he is totally disabled.⁵ And fourth, the miner must prove the total disability is due to pneumoconiosis.⁶

With those four principal conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principal conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. M.'s case, his most recent, prior claim was denied in March 2001 for failure to prove total disability. That denial was based on medical evidence developed through June 2000. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the new medical evidence developed since June 2000 to determine whether Mr. M. can now prove a total respiratory disability.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii)

³20 C.F.R. § 718.202.

⁴20 C.F.R. § 718.203(a).

⁵20 C.F.R. § 718.204(b).

⁶20 C.F.R. § 718.204(a).

arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises*, 49 F.3d 993 (3d Cir. 1995), the court stated to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. M. has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. M. must demonstrate total respiratory or pulmonary disability through 1) the presence of complicated pneumoconiosis, 2) pulmonary function tests, 3) arterial blood-gas tests, or 4) medical opinion.

1. Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921(c)(3)(A) and (C), as implemented by 20 C.F.R. § 718.304(a), Congress determined that if a miner is suffering from a chronic dust disease of the lung “which when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C...there shall be an irrebuttable presumption that he is totally disabled by pneumoconiosis. . . .”⁷ This type of large opacity is called “complicated pneumoconiosis.” 20 C.F.R. §§ 718.304(b) and (c) also permits complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

According to the U.S. Court of Appeals for the Fourth Circuit⁸ in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by “congressionally defined criteria.” As a result, the statute’s definition of complicated pneumoconiosis as radiographic evidence of one or more

⁷The definition section of the standard ILO chest x-ray classification worksheet, Form CM 9331, states concerning large opacities that “the categories are defined in terms of dimensions of the opacities.” The form then lists three categories, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities “larger or more numerous than Category A” whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

⁸Mr. M.’s case arises within the jurisdiction of this court.

large opacities categorized as size A, B, or C, 30 U.S.C. 921(c)(3)(A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921(c)(3)(B) and (C). *Id.* at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921(c)(3)(B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921(c)(3)(A).⁹ Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community's definition of the disease. *Id.* at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated,

if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id.*

Referencing a 1993 Fourth Circuit case, *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993), the BRB in *Mullins v. Plowboy Coal Co.*, BRB No. 04-0716 BLA (July 8, 2005) (unpub.) emphasized that in determining whether complicated pneumoconiosis is present, an ALJ "must weigh together all of the evidence relevant to the presence or absence of pneumoconiosis." That mandate is consistent with other case law indicating that all evidence relevant to whether the miner has pneumoconiosis must be weighed. *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

Further, in *Mullins v. Plowboy Coal Co.*, BRB No. 06-0900 BLA (Aug. 30, 2007) (unpub.), the Board directed that during the adjudication of each subsection under 20 C.F.R. § 304, chest x-ray, biopsy/autopsy, and other medical evidence including CT scans, an administrative law judge must determine whether the preponderance of the evidence under the subsection establishes both the presence of pneumoconiosis (chronic lung disease) and the presence of a large pulmonary opacity greater than one centimeter.

In light of these statutory, regulatory, and judicial principles, and considering the BRB's specific directions, my adjudication of whether Mr. M. is able to invoke the irrebuttable presumption under § 718.304 involves a two step process.

First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C, consistent with complicated pneumoconiosis, under recognized standards;¹⁰ or b) biopsy evidence shows

⁹See also 20 C.F.R. §§ 718.304(b) and (c).

¹⁰According to the Board, an ILO interpretation that notes a mass that is larger than one centimeter in the comments section but does not diagnose pneumoconiosis with an opacity size of A, B, or C is not sufficient to assist a claimant

massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities and establish the presence of pneumoconiosis.

Second, if complicated pneumoconiosis opacities are established, I must also evaluate the relevant evidence under all three subsections of 20 C.F.R. §718.304 together to determine whether the claimant has complicated pneumoconiosis.

Chest X-Rays, 20 C.F.R. § 718.304(a)

Date of x-ray	Exhibit	Physician	Interpretation
December 11, 2001	DX 38	Dr. Mullens, BCR ¹¹	Chronic interstitial lung disease with multiple ill defined bilateral pulmonary nodules
June 28, 2002	DX 15	Dr. Forehand, B	Positive for pneumoconiosis, profusion 1/2, ¹² type p opacities, ¹³ category B large opacities, multiple pulmonary nodules, 1 to 2 centimeters in diameter, left upper lobe and all three zones right side. 1998 biopsy negative for malignancy.
(same)	DX 17	Dr. Goldstein, B	Multiple large nodules; rule out cancer. ¹⁴

in establishing pneumoconiosis under 20 C.F.R. § 718.304(a). *Mullins v. Plowboy Coal Co.*, BRB No. 06-0900 BLA (Aug. 30, 2007) (unpub.), slip op. fn 8.

¹¹As I informed the parties at the hearing (TR, pages 7 and 8), I take judicial notice of Dr. Mullens' board certification and have attached the certification documentation. The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202(a)(1)(ii).

¹²The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1.

¹³There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, *RESPIRATORY DISEASES* 581 (3d ed. 1981).

¹⁴Since Dr. Goldstein provided his comments in a quality review of the June 28, 2002 chest x-ray associated with the DOL examination, he did not determine either the size of the large nodules or whether they were consistent with pneumoconiosis.

(same)	DX 37 & DX 39	Dr. Hippensteel, B	Positive for pneumoconiosis, profusion 1/0 type p/s opacities, no large opacities consistent with pneumoconiosis; partly calcified 1.5 centimeter nodule, left upper lobe. Scattered nodules 0.5 to 2.5 centimeters present in left lower lobe, but more in right lower lobe. Pattern does not look like simple or complicated pneumoconiosis, more compatible with nodular sarcoidosis, considering elevated "ACE".
September 12, 2002	DX 37	Dr. Wheeler, BCR, B	Negative for pneumoconiosis and no large opacities consistent with pneumoconiosis; scattered 5 millimeters to 2 centimeters masses in right lung, compatible with granulomatous disease or metastases; subtle linear interstitial infiltrate or fibrosis compatible with inflammatory disease or possible lymphatic spread.
(same)	CX 3	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/3, type p/s opacities, category B large opacities right lower zone and both upper zones; summed diameter of large opacities 55 to 60 millimeters, consistent with category B complicated pneumoconiosis; however metastatic cancer would have similar appearance.
October 22, 2003	CX 1	Dr. Pathak, B	Positive for pneumoconiosis, profusion 2/2, type q/t opacities, category B large opacities; emphysema; several larger nodular densities measuring between 1 and 2 centimeters in size in all six zones.
(same)	CX 2	Dr. Robinette, B	Positive for pneumoconiosis, profusion 2/2, type p/q opacities, category A large opacities, nodular density consistent with coal workers' pneumoconiosis; however needs comparison to old x-rays.
(same)	EX 2	Dr. Scatarige, BCR, B	Negative for pneumoconiosis and no large opacities consistent with pneumoconiosis; unchanged (since 1997) 1.5 centimeter nodule in the left upper lobe; interval appearance of interstitial infiltrates involving all lobes and multiple bilateral nodules 5 millimeters to 2 centimeters; emphysema; consistent with metastatic disease, fungal disease, and lymphoma; pneumoconiosis unlikely since no interstitial present in prior chest x-ray study.
(same)	EX 6	Dr. Renn, B	Positive for pneumoconiosis, profusion 1/1, type q/q opacities; no large opacities consistent with pneumoconiosis; mass densities in right lower and left upper lobes consistent with metastatic disease and not progressive massive fibrosis; small nodular densities consistent with metastatic disease. Left lower lobe nodule has marginally increased since 1997.
May 12, 2004	CX 5	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/2, type p/q opacities, category B large opacities, 15 millimeter diameter large opacities in upper zones, 25 millimeter large opacity in right lower zone with adjacent emphysematous change.

(same)	EX 1	Dr. Scatarige, BCR, B	Negative for pneumoconiosis and no large opacities consistent with pneumoconiosis; unchanged and benign 1.5 centimeter mass left lower lobe, scattered nodules in right upper lung and right lower lung of questionable etiology; emphysema present. Interval appearance of interstitial infiltrate all lobes and multiple bilateral nodules 5 mm to 2 cm, possible chronic pneumonia, infiltrative disease, neoplasm, Wegner's disease or rare amyloidosis. Central infiltrates have resolved since 2003.
June 2, 2004 (2 x-rays)	CX 4	Dr. Mullens	Multiple ill defined masses and reticulonodular interstitial disease.
(same)	EX 10	Dr. Hippensteel, B	Right apical pneumothorax, 2 centimeter nodule in right lower lobe, 1 centimeter nodule in left upper lobe; consistent with sarcoidosis rather than coal workers' pneumoconiosis.

Since Dr. Mullens did not report any large opacities, the December 11, 2001 chest x-ray is negative for large pulmonary opacities consistent with pneumoconiosis.

Similarly, in the absence of Dr. Mullens' finding any large opacities and Dr. Hippensteel's attribution of the 2 centimeter mass to sarcoidosis, the June 2, 2004 radiographic study is negative for the presence of a large pulmonary opacity consistent with pneumoconiosis.

In the October 22, 2003 chest x-ray, Dr. Pathak and Dr. Robinette, both B readers, observed a pneumoconiosis-related large opacity. Dr. Renn, also a B reader, and Dr. Scatarige, a dual qualified radiologist, did not. Based on Dr. Scatarige's superior credentials,¹⁵ his negative findings have greater probative weight. As a result, the October 22, 2002 is negative for the presence of a large pulmonary opacity consistent with pneumoconiosis.

Dr. Wheeler, a dual qualified radiologist, found no evidence of a large pulmonary opacity attributable to pneumoconiosis in the September 12, 2002 chest x-ray. Dr. Alexander, also a dual qualified radiologist, observed a Category A opacity consistent with pneumoconiosis in the same film. Since the radiologists have similar qualifications, their professional dispute renders the September 12, 2002 film inconclusive.

Considering the May 12, 2004 chest x-ray, Dr. Scatarige and Dr. Alexander had a similar professional standoff. Consequently, the May 12, 2004 film is also inconclusive for the presence of a large pulmonary opacity consistent with pneumoconiosis.

In the June 28, 2002 film, Dr. Forehand, a B reader, found a category B opacity which he believed was complicated pneumoconiosis. Dr. Hippensteel, a B reader, disagreed. Dr. Goldstein simply reported the presence of multiple large nodules. Since Dr. Forehand and Dr. Hippensteel have similar qualifications to interpret black lung chest x-rays, and Dr. Goldstein's

¹⁵See *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader).

comments are incomplete, I consider the June 28, 2002 chest x-ray to be inconclusive for the presence of a large pulmonary opacity consistent with pneumoconiosis.

In summary, setting aside the three inconclusive radiographic studies of September 12, 2002, May 12, 2004, and June 28, 2002, the remaining three films are negative for a pneumoconiosis-related large opacity. Accordingly, Mr. M. is unable to prove the presence of large pulmonary opacity associated with pneumoconiosis through the preponderance of the chest x-ray evidence under 20 C.F.R. § 718.304(a).

Biopsy, 20 C.F.R. § 718.304(b)

On June 2, 2004, Dr. Richard Buddington, a board certified pathologist, evaluated the tissue sample obtained from the margin of the large lesion in the right lower lobe (CX 4)). Dr. Buddington observed “scanty amounts of skeletal muscle and anthracotic pigment.”

When Dr. Kirk Hippensteel reviewed Dr. Buddington’s report he opined the procedure failed to isolate a cause of Mr. M.’s breathing problems (EX 10). He also noted that the needle did not penetrate the pulmonary mass and Dr. Buddington did not report the presence of pulmonary cells in the tissue sample.

The needle biopsy had the potential for identifying the specific nature of Mr. M.’s pulmonary masses. Unfortunately, the development of a pneumothorax during the procedure thwarted the attempt. Although Dr. Buddington’s finding of anthracotic pigment is not inconsistent with the presence of coal workers’ pneumoconiosis, 20 C.F.R. § 718.202(a)(2) states a biopsy finding of anthracotic pigmentation is insufficient to establish the presence of pneumoconiosis. As a result, Dr. Buddington’s report does not provide a definitive diagnosis. Accordingly, I find the 2004 lung biopsy is insufficient to establish the presence of massive fibrosis under 20 C.F.R. § 718.304(b).

Other Evidence, 20 C.F.R. § 718.304(c)

In Mr. M.’s case, two other types of medical evidence, CT scans and PET scan, are available.

*CT Scans*¹⁶

August 20, 2002 To evaluate the possibility of a new pulmonary nodule, Dr. Richard Mullens, board certified in diagnostic radiology, evaluated an August 20, 2002 CT scan, consisting of five millimeter intervals, conducted that day and compared the results with prior studies from December 1998 and April 2001 (DX 38). Dr. Mullens found a diffuse reticular nodular interstitial pattern throughout both lungs. Several small reticular nodules were located in

¹⁶As Dr. Mullens observed, the improved CT scan technology provided enhanced detail of the lung through sectional images. Based on his comments, and the absence of any adverse quality critique by Dr. Hippensteel, I find the CT scans are medically acceptable and relevant to the determination of Mr. M.’s entitlement to benefits. See *Tapley v. Bethenergy Mines, Inc.*, BRB No. 04-0790 BLA (May 26, 2005) (unpub.).

the mid-lung zones. Dr. Mullens also noted “multiple, larger bilateral speculated nodules with adjacent parenchymal scarring and architectural distortion.” While improved technology had enhanced the detail of the images, Dr. Mullens found little change from the findings of the prior studies. In closing, Dr. Mullens stated that the “area of concern in a recent chest x-ray is not known” because he did not have the chest x-ray or report for correlation.¹⁷

September 12, 2002 Dr. Kirk E. Hippensteel, board certified in pulmonary disease, interpreted a September 12, 2002 CT scan of Mr. M. (DX 37). He observed some reticular and nodular infiltrates, more significant in lung bases than in apices. There were areas of larger nodules, mostly in the right lower lobe and one partly calcified two centimeter nodule in the left upper lobe. The nodules did not “have the distinct suggestion of coalescence as occurs with complicated coal workers’ pneumoconiosis.” Additionally the nodules were “not associated with an upper lobe predominance of interstitial changes expected with coal workers’ pneumoconiosis.” Dr. Hippensteel opined the “mostly reticular nature of abnormalities in most of [the] lung fields” was “more compatible with sarcoidosis.”

June 2, 2004 In an effort to further evaluate the multiple lung masses and an enlarged mass in the lower right lower lobe, Dr. Richard Mullens assisted with a fine needle biopsy on June 2, 2004 by using a CT scan to guide the biopsy (CX 4). During the procedure, Dr. Mullens observed a right lower lobe nodule. One sample was obtained through the posterior margin of the lesion. Because Mr. M. then developed a small pneumothorax,¹⁸ no additional tissue samples were taken. Images obtained after the procedure showed right pneumothorax as well as minimal parenchymal hemorrhage adjacent to the lesion.

When Dr. Hippensteel reviewed the June 2, 2004 CT scan, he observed the mass in the right lower lobe and right pneumothorax (EX 10). Dr. Hippensteel explained that when Dr. Mullens performed the needle biopsy, Mr. M. developed a small pneumothorax during his first pass. Therefore, Dr. Mullens did not take any additional core samples. The biopsy needle point is located at the posterior edge of the right lower lobe lesion but has not penetrated the nodule. There appeared to be calcification in peripheral nodules most densely in the left upper lobe nodule and calcification in hilar and subcarinal lymph nodes. This is associated with some basilar predominant reticular nodular changes in lung fields, more consistent with a diagnosis of inflammation from sarcoidosis which affects both lung parenchyma and lymph nodes, rather than coal workers’ pneumoconiosis.

Discussion Although Dr. Mullens observed opacities in the June 12, 2002 CT scan, he neither indicated that they were the equivalent of a chest x-ray opacity greater than one centimeter nor that they were consistent with pneumoconiosis. Consequently, his evaluation of the June 12, 2002 CT scan is insufficient to establish the presence of complicated pneumoconiosis.

¹⁷In a medical record review (EX 10), Dr. Hippensteel suggested that Dr. Mullens’ finding were compatible with sarcoidosis. However, Dr. Hippensteel did not actually interpret the images from this study.

¹⁸An accumulation of air or gas in the pleural space which may occur spontaneously as a result of . . . a pathological process. DORLAND’S ILLUSTRATED DICTIONARY 1319 (28th ed. 1994).

In his assessment of the September 12, 2002 CT scan, Dr. Hippensteel did not make the requisite equivalency finding concerning the two centimeter mass and concluded the large mass was not consistent with pneumoconiosis. As a result, the September 12, 2002 CT scan is negative for complicated pneumoconiosis.

Although he identified a large pulmonary mass in the June 2, 2004 CT scan, Dr. Mullens did not indicate its size, make any equivalency assessment, or indicate the mass was consistent with pneumoconiosis. Likewise, Dr. Hippensteel did not give a measurement for the large pulmonary nodule. He also stated the mass was more consistent with inflammatory sarcoidosis than pneumoconiosis. In light of their assessment, the June 2, 2004 CT scan does not establish the presence of complicated pneumoconiosis.

In summary, for various reasons, the CT scans from August 20, 2002, September 12, 2002, and June 2, 2004 do not establish the presence of complicated pneumoconiosis under 20 C.F.R. § 718.304(b).

PET Scan

On May 10, 2004, Dr. Richard Mullens conducted a whole body PET scan of Mr. M. (CX 4). Though the distribution of the radioactive material throughout the chest was mostly normal, Dr. Mullens identified “multiple foci of increased uptake in the lungs bilaterally.” Three “small hypermetabolic lesions” were present in the right upper lobe. The right lower lobe contained “multiple contiguous somewhat linear shaped areas of FDG accumulation.” In the left lower lobe “two very small areas of faint uptake” were present. Uptake was also present “in both hilar regions as well as mid uptake in the subcarinal region.” In Dr. Mullens’ opinion, the very mild uptake on the left was “probably due to the patient’s CWP/silicosis.” On the other hand, the “very intense hypermetabolic lesions” on the right side could “be found with either conglomerate masses associated with CWP or neoplasm.” Finally, both the bilateral hilar uptake and the subcarinal uptake occur with coal workers’ pneumoconiosis. For a more specific diagnosis of the largest lesion, located in the right lower lobe, Dr. Mullens believed a biopsy was necessary.

When Dr. Kirk Hippensteel attempted to interpret the PET scan, he found his CD copy unreadable (EX 10). Nevertheless, upon reviewing Dr. Mullens’ report on the study, Dr. Hippensteel stated, “I agree with his interpretation.” At the same time, Dr. Hippensteel added, “I would note that sarcoidosis can create increased uptake as well, and he [Dr. Mullens] did not even consider such an inflammatory disease in a differential of these findings which is a significant omission.”

In considering these two assessments, I note that while Dr. Mullens did not specifically diagnose complicated pneumoconiosis, he believed the small uptake in the left areas of the lungs was most likely due to pneumoconiosis/silicosis and Dr. Hippensteel did not refute that finding, even though he faulted Dr. Mullens for not also considering the possible etiology of sarcoidosis, another inflammatory lung disease. However, even though Dr. Mullens’ PET scan interpretation supports a finding of pneumoconiosis, the radiologist did not specifically identify any large

pulmonary nodules with this particular test. As a result, PET Scan provides no evidence of large opacities that would be the equivalent of radiographic opacities greater than one centimeter. Consequently, the PET scan does not establish complicated pneumoconiosis under 20 C.F.R. § 718.304(c).

Conclusion

The preponderance of the radiographic evidence is negative for the presence of a large pulmonary opacity consistent with pneumoconiosis. The biopsy evidence is insufficient to the presence of massive fibrosis. The other medical evidence, including CT scans and a PET scan, do not establish the presence of pneumoconiosis. Consequently, Mr. M. is unable to prove the presence of complicated pneumoconiosis under 20 C.F.R. § 718.304(a)-(c) as means to establish total disability under 20 C.F.R. § 718.204(b)(1).

2. Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV ¹ pre ¹⁹ post ²⁰	FVC pre post	MVV pre post	% FEV ¹ / FVC pre post	Qualified ²¹ pre Post	Comments
DX 37 & DX 38	April 20, 2001 Dr. Robinette	70 66.0"	2.54	3.66		69.4%	No ²²	Normal
DX 13	June 28, 2002 Dr. Forehand	71 67.0"	2.75	4.29	113	64.1%	No ²³	Normal ventilatory pattern
DX 37	Sept. 12, 2002 Dr. Hippensteel	71 69.0"	2.65 2.70	4.06 4.03	91	65.3%	No ²⁴ No	
EX 1	May 12, 2004 Dr. McSharry	73 68.0"	2.78 2.90	3.91 4.23	92	67.0%	No ²⁵ No	Essentially normal

None of the pulmonary function tests reached the regulatory thresholds for total disability. As a result, Mr. M. cannot establish total disability under 20 C.F.R. § 718.204(b)(2)(i).

¹⁹Test result before administration of a bronchodilator.

²⁰Test result following administration of a bronchodilator.

²¹Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

²²The qualifying FEV1 number is 1.59 for age 70 and 65.7."

²³The qualifying FEV1 number is 1.63 for age 71 and 66.9."

²⁴The qualifying FEV1 number is 1.79 for age 71 and 68.9."

²⁵The qualifying FEV1 number is 1.69 for age 71 (eldest age referenced) and 67.7."

3. Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ² (rest) pCO ² (exercise)	pO ² (rest) pO ² (exercise)	Qualified ²⁶	Comments
DX 37 & DX 38	April 20, 2001 Dr. Robinette	41	81	No ²⁷	Normal, diffusing capacity slightly reduced
DX 12	June 28, 2002 Dr. Forehand	39 34	68 72	No ²⁸ No ²⁹	No hypoxemia
DX 37	Sept. 12, 2002 Dr. Hippensteel	39.8 31.7	69.0 76.1	No No ³⁰	Normal
EX 1	May 12, 2004 Dr. McSharry	38.2	79.6	No ³¹	

None of the arterial blood gas studies reached the regulatory thresholds for total disability. As a result, Mr. M. cannot establish total disability under 20 C.F.R. § 718.204(b)(2)(ii).

4. Medical Opinion

Total disability may also be established under 20 C.F.R. § 718.204(b)(2)(iv) through the preponderance of the more probative medical opinion. Under this regulatory provision, total disability may be found through reasoned medical opinion:

if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b)(1) of this section.

Twenty C.F.R. § 718.204(b)(1) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. To evaluate total disability under these provisions, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of his respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

²⁶To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO² level, the value of the coal miner's pO² must be equal to or less than corresponding pO² value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

²⁷For the pCO² of 40 to 49, the qualifying pO² is 60, or less.

²⁸For the pCO² of 39, the qualifying pO² is 61, or less.

²⁹For the pCO² of 34, the qualifying pO² is 66, or less.

³⁰For the pCO² of 32, the qualifying pO² is 68, or less.

³¹For the pCO² of 38, the qualifying pO² is 62, or less.

Based on Mr. M.'s testimony, I find that during his last coal mine employment as a roof bolt helper, he regularly engaged in heavy manual labor.

Having established the physical requirements of Mr. M.'s last coal mining job, I turn to the medical opinions on whether he is capable of returning to that work.

Dr. Emory Robinette
(DX 37, DX 38, and CX 4)

Dr. Robinette, board certified in internal medicine and pulmonary diseases, treated Mr. M. for breathing problems twice a year.³² In June 2000 and December 2000, Dr. Robinette again saw Mr. M. as part of his on-going periodic treatment of Mr. M.'s breathing problem. Upon examination, Dr. Robinette heard diminished breath sounds and an oxygen saturation of 93%. Dr. Robinette diagnosed progressive massive fibrosis with underlying coal workers' pneumoconiosis.

On June 11, 2001, Dr. Robinette noted the presence of a 2 centimeter mass in the upper lobe of Mr. M.'s left lung established by earlier radiographic studies, which was evidence of complicated pneumoconiosis. A chest exam revealed diminished breath sounds with a few wheezes heard and mild prolonged expiratory phase. A pulmonary function test produced normal results.

Dr. Robinette saw Mr. M. on December 11, 2001 and noted Mr. M.'s history of black lung disease with left upper lobe lung mass, and documented pulmonary fibrosis with profusion 3/2 and type p/q opacities. A chest exam revealed diminished breath sounds with a few wheezes heard and prolongation of the expiratory phase. A pulmonary function test produced normal results.

In preparation for Mr. M.'s hospital admission on June 2, 2004, Dr. Robinette conducted a medical examination of Mr. M. on May 25, 2004. Mr. M. was being admitted to the hospital for an elective biopsy of an enlarging right lower lung mass. Dr. Robinette believed Mr. M. had pneumoconiosis with a 2 centimeter nodule in the right lower lobe and 2.5 centimeter nodule in the left upper lobe. He also noted Mr. M.'s history of pneumoconiosis with reticulonodular radiographic abnormalities, including the October 1998 diagnostic bronchoscopy evaluation which was negative for malignancy. In July 2002, an x-ray was done and consistent with pneumoconiosis, showing pulmonary nodules 1 to 2 centimeters in size.

As summarized by Dr. Robinette, a CT scan performed on August 20, 2002 demonstrated evidence of diffuse reticulonodule interstitial disease with smaller interstitial opacities, multiple large spiculated opacities and little change from a past CT scan in 1998. An x-ray from October 2003 showed an increased nodular density in the right lower lobe. A PET scan completed on

³²As background information, Dr. Robinette first treated Mr. M. in 1990 when he presented with breathing complaints. In the fall of 1998, Mr. M. was evaluated for possible metastatic lung disease when radiographic evidence showed the presence of two centimeter masses in the left upper lobe and the right lower lobe. Smaller pulmonary nodules were also present in the left lower lobe and the right middle lobe. A diagnostic bronchoscopy was negative for a malignancy (DX 38).

May 14, 2004 and interpreted by Dr. Mullens showed multiple foci of increased uptake in the lungs bilaterally. On the left side, there was a mild area of uptake consistent with coal workers' pneumoconiosis; but on the right side there were multiple hypermetabolic lesions. Dr. Robinette told Mr. M. that the pattern of radiographic development may indicate a lung neoplasm. As a result, Dr. Robinette suggested a diagnostic needle biopsy of the right lung mass. A chest exam at this time revealed diminished breath sounds without significant bronchospasm and prolonged expiratory phase. Dr. Robinette diagnosed complicated coal workers' pneumoconiosis and an enlarging right lower lung mass.

Dr. J. Randolph Forehand
(DX 14 and DX 16)

On June 28, 2002, Dr. Forehand, board certified in pediatrics, allergy and immunology, conducted a pulmonary evaluation of Mr. M. who reported sputum, wheezing and dyspnea. Mr. M. had a coal mine employment history of 28 1/2 years. He smoked 3-4 cigars and 6 to 8 pipes full of tobacco per day from 1948 to 1968. Dr. Forehand heard rare crackles in the bases of Mr. M.'s lungs. In the chest x-ray, Dr. Forehand observed complicated coal workers' pneumoconiosis with large category B opacities. The pulmonary function test was normal and the arterial blood gas study revealed no abnormalities. Dr. Forehand diagnosed complicated pneumoconiosis caused by coal dust exposure. The physician believed that the complicated pneumoconiosis caused serious damage to Mr. M.'s lungs which rendered him totally and permanently disabled and unable to return to his previous coal mining job. No other lung disease contributed to Mr. M.'s total disability.

Dr. Kirk Hippensteel
(DX 37, EX 7 and EX 10)

On September 12, 2002, Dr. Hippensteel, board certified in internal medicine, pulmonary disease and critical care, conducted a pulmonary evaluation of Mr. M. who reported breathing problems since 1971, which cause him to become short of breath after climbing more than one flight of stairs. Mr. M. was a coal miner for 31 years, until October 1986. While employed in the coal mines, he was a roof bolter and shoveled coal, which required heavy labor. Mr. M. gets rare upper respiratory infections but has never had pneumonia, TB (tuberculosis) or been hospitalized for his breathing problems. He has never had bird or chicken exposure. From 1946 to 1968, Mr. M. smoked 5 to 6 cigars and 3 to 5 pipes full of tobacco per day. A chest exam revealed a mild increase in AP chest diameter with minimal scattered rales in bases. The pulmonary function test and arterial blood gas study produced normal results.

A chest x-ray was taken and interpreted by Dr. Wheeler who found scattered 5 millimeter to 2 centimeter masses in the lungs compatible with granulomatous disease or metastasis. Based on his review of a CT scan, Dr. Hippensteel believed that the nodules do not have the distinct suggestion of coalescence as occurs with complicated coal workers' pneumoconiosis and are not associated with upper lobe predominance of interstitial changes expected from pneumoconiosis. The mostly reticular nature of abnormalities was more consistent with sarcoidosis. Mr. M.'s angiotensin converting enzyme ("ACE") level was elevated to 87,³³ consistent with a diagnosis

³³According to the medical report, the normal range is 8 to 52 (DX 37).

of sarcoidosis, which is a granulomatous disease. The ACE level is not usually elevated with coal workers' pneumoconiosis. For these reasons, Dr. Hippensteel concluded that the abnormalities on x-ray were most compatible with nodular sarcoidosis, which is a noninfectious granulomatous disease of the lungs, unrelated to coal mine dust exposure. "It is variable in its effects on lung function when present." Its presence has not caused any ventilatory or gas exchange impairment. As a result, Mr. M. does not have any pulmonary impairment that would prevent him from going back to his previous job in the mines.

After reviewing an extensive medical record dating back to 1972, Dr. Hippensteel concluded that the disease process in Mr. M.'s lungs is not consistent with coal workers' pneumoconiosis because there was no progression of the disease. Dr. Hippensteel explained:

Even though coal workers' pneumoconiosis can be progressive after leaving work in the mines, this case shows that it did not progress significantly during active exposure, and then when there was radiographic progression, it was not associated with any development of pulmonary function abnormalities, which would not be expected with rapidly progressive massive fibrosis.

Instead, most of the findings are consistent with sarcoidosis; although it appears there was also an unrelated granulomatous process in the left upper lobe. While Dr. Hippensteel acknowledges that Mr. M. may have simple pneumoconiosis, he does not believe Mr. M. has progressive massive fibrosis or a total disability that would prevent him from returning to his previous coal mine employment.

In a deposition conducted on May 24, 2004, after reviewing additional medical records, Dr. Hippensteel testified about his September 2002 evaluation of, and medical conclusions regarding, Mr. M. The arterial blood gas study conducted by the physician showed normal results that even improved with exercise. The pulmonary function test was also normal. These results were consistent with the studies done by Dr. Robinette in April 2001 and Dr. Forehand in June 2002. Mr. M.'s breathing test results were even better with Dr. McSharry, who Mr. M. saw a year and a half after he saw Dr. Hippensteel.

Dr. Wheeler interpreted the chest x-ray taken as part of Dr. Hippensteel's examination. The mass noted by Dr. Wheeler in Mr. M.'s left lobe dates back to 1970 in the medical records. Based on his review of the CT scan, Dr. Hippensteel concluded that the abnormalities present in Mr. M.'s chest were more compatible with granulomatous disease secondary to sarcoidosis rather than coal workers' pneumoconiosis for several reasons.

First, the multiple radicular and nodular infiltrates were more significant in the lung bases. That location is not consistent with coal workers' pneumoconiosis which causes "a predominance in the upper lobes."

Second, the radicular nature of the nodules is "more compatible with sarcoidosis. Coal workers' pneumoconiosis produces a "more nodule pattern."

Third, the larger nodules did not have “any distinct suggestion of coalescence” as would be expected if it were complicated pneumoconiosis. These large nodules also were not associated with any upper lobe predominance of interstitial changes. In particular, the calcified nodule in the left upper lobe, which has been present since the 1970’s, was not referable to a large opacity from pneumoconiosis. If the mass in the left upper lobe was related to a chronic dust disease of the lung and coal mine employment, it would be a category A opacity. In that case, Dr. Hippensteel would not have expected the mass to stay the same size from 1971 to 1986. Usually with coal workers’ pneumoconiosis, a coalescence of smaller opacities occurs, which in turn makes the mass larger over time.

Fourth, detailed images from the CT scan coupled with the ACE levels, point to a granulomatous disease. A granulomatous disease occurs when the lung reacts to an infection or “certain inflammatory agents” by encasing the irritant and causing a lesion. It will produce calcification over time. There are many types of granulomatous disease, including tuberculosis, fungal disease, and sarcoidosis. However, coal workers’ pneumoconiosis is not a granulomatous disease because it does not produce the same type of reaction in the lung.

Fifth, Mr. M.’s lack of pulmonary function problems as the radiographic changes progressed, the absence of radiographic changes during Mr. M.’s continued exposure to coal dust, and the onset of radiographic changes only after he left the mines led Dr. Hippensteel to conclude that Mr. M. does not have simple or complicated pneumoconiosis, or that the larger masses are in any way related to a chronic dust disease of the lung. Although progression of coal workers’ pneumoconiosis can occur after a miner has left the mines, it is expected that it would at least occur close to the time that the miner was working in the mines.

Dr. Scatarige interpreted the October 22, 2003 chest x-ray suggesting the presence of cytotis lymphoma, which is a granulomatous disease; however, with all of the other medical evidence of record, Dr. Hippensteel does not believe that is a correct diagnosis. Dr. Scatarige also mentioned Wegener’s and amyloidosis as possible diagnoses, both diseases that create a nodular pattern in the lung like coal workers’ pneumoconiosis.

To determine what specific granulomatous disease Mr. M. had, Dr. Hippensteel conducted an ACE test, which showed an elevated level indicative of sarcoidosis. Although the test “is not completely specific” for sarcoidosis, an high level increases the likelihood that sarcoidosis is present. Though a person can have an elevated level from this test and not have sarcoidosis; coal workers’ pneumoconiosis does not cause an elevated level.

Based on all of these findings and reasons, Dr. Hippensteel believes sarcoidosis is the “probable reason” for elevation of the enzyme level. The mass in Mr. M.’s left upper lobe, which has been present for 30 years does not appear to be the result of sarcoidosis, but rather “some other granulomatous process, possibly infectious from histoplasmosis or something like that.” Dr. Hippensteel also concludes that Mr. M. does not have a respiratory impairment and can return to his previous coal mining job. The cause of the x-ray abnormalities is sarcoidosis and possibly another type of granulomatous disease, which is not related to coal mine dust.

On July 1, 2004, Dr. Hippensteel reviewed additional medical records including Dr. Robinette's treatment notes, a CT scan conducted on August 20, 2002 by Dr. Mullens, the chest x-ray interpretations by Dr. Wheeler and Dr. Alexander of the September 2002 film and interpretations by Dr. Pathak, Dr. Renn, Dr. Robinette and Dr. Scatarige of the October 2003 film, Dr. McSharry's May 2004 medical report and report of June 2004 hospital admission, including the needle lung biopsy attempt.

In regards to the biopsy, Dr. Hippensteel concluded the procedure failed to produce any "meaningful" result. The biopsy did not identify any cause for the lung masses. Dr. Hippensteel further concluded that the physicians who cared for Mr. M. were working under a preconception that Mr. M. had coal workers' pneumoconiosis and did not evaluate the evidence to see if another diagnosis was more appropriate. In particular, he faulted the physicians for failing to include sarcoidosis in their consideration of etiology. Dr. Hippensteel continues to believe that sarcoidosis is the "probable diagnosis."

Dr. Roger G. McSharry
(EX 1 and EX 8)

On May 12, 2004, Dr. McSharry, board certified in internal medicine, pulmonary disease and critical care, conducted a pulmonary evaluation of Mr. M, who reported a 31 year history of coal mining, 28 years of which were underground. His last job in mining was as a roof bolter, where he did moderately strenuous work setting jacks. He stopped working in 1986 due to shortness of breath and back problems. He smoked 8 to 9 cigars a day and 3 to 4 pipefuls of tobacco a day for 15 to 18 years before quitting permanently in 1968. Mr. M. is able to walk on level ground slowly but has difficulty going up hills and stairs because of shortness of breath. The chest examination was normal and breath sounds were clear. The chest x-ray interpretation by Dr. Scatarige was negative for pneumoconiosis. The pulmonary function test and arterial blood gas study were normal. Dr. McSharry concluded that Mr. M. had significant coal dust exposure and exertional dyspnea without strong suggestion of asthmatic component.

Dr. McSharry also reviewed medical records dating back to 1971 in addition to CT scans from 1998, 1999, 2002, and 2004. He noted that the left upper lobe nodule had not progressed over the years. Likewise, many of the other nodules in the right and left lung had not changed. At the same time, "[t]he right mid lung zone shows some progressive enlargement of nodules into a more confluent mass over the time since 1998."

Upon review of all the evidence, Dr. McSharry believed the evidence was inadequate to justify a diagnosis of coal workers' pneumoconiosis. Although Mr. M. had mined coal for many years, the chest x-rays did not show typical abnormalities associated with coal workers' pneumoconiosis – "rounded nodularity predominating the upper lung zones." Rather, the multiple round densities in the periphery of Mr. M.'s lungs are most suggestive of pulmonary granulomas as well as the larger lesions in the left upper lung zone which are unchanged over time and the progressive abnormalities in the right mid and lower lung zones, which are consistent with granulomatous disease. Dr. McSharry also bases his finding that Mr. M. does not have coal workers' pneumoconiosis on his normal pulmonary function tests. It would be unusual

for a person with coal workers' pneumoconiosis with progressive massive fibrosis to have normal function tests.

In addition, Dr. McSharry observed the lack of evidence showing either an obstructive or restrictive lung disease. Thus, Mr. M. does not have a pulmonary disability; there is no reason he could not return to his previous coal mine employment. Dr. McSharry believes that the abnormalities seen on chest x-rays "in all likelihood represent some form of granulomatous lung disease, either from old infection or possibly from another process such as pulmonary sarcoidosis." However, Dr. McSharry explained that "the elevated angiotensin converting enzyme level mentioned in the record does not definitely prove sarcoidosis, and [he] could not with any certainty say that these lesions represent pulmonary sarcoidosis, but that is a possibility." Finally, with respect to the left upper lobe mass seen radiographically for 30 years, this lesion cannot "reasonably be attributed" to a lesion of progressive massive fibrosis since it has not progressed during Mr. M.'s life.

In a deposition on June 3, 2004, Dr. McSharry stated that the pulmonary function and arterial blood gas tests conducted by him and other physicians in the record around that time did not show any respiratory disability. Consequently, he would not place any restrictions on Mr. M.'s ability to do heavy manual labor. Moreover, the lesions that Dr. McSharry observed on CT scans and chest x-rays were not consistent with the type associated with coal mine dust exposure. The pulmonary nodules, which changed over time are more representative of cancers and granulomatous diseases, which is distinct from changes seen with pneumoconiosis. Pneumoconiosis is a fibrotic disease, not a granulomatous disease. It is common for a person to have abnormalities from granulomatous disease and not have a history of being seriously ill.

"The most common presentation" of sarcoidosis "is enlarged lymph glands in the chest with no symptoms whatsoever." Sarcoidosis can also cause other abnormalities in the lungs, including nodules that are either stable or change over time, with or without evidence of impairment of lung function. Sarcoidosis can cause an elevated angiotensin enzyme level. Some reports have found coal workers' pneumoconiosis causing an elevated level of the enzyme as well. The evidence is not clear and Dr. McSharry doesn't believe pneumoconiosis will cause elevated levels. At the same time, Dr. McSharry cannot diagnose sarcoidosis without a biopsy that showed the lesions look like sarcoidosis because Mr. M. "is not the most typical case of sarcoidosis."

Dr. McSharry concurs with Dr. Hippensteel's finding that the old lesion in the left upper lobe of the lung is unrelated to the other lesions in Mr. M.'s lungs. Dr. McSharry does not believe the lesion is caused by coal mine dust exposure because he would expect there to be other abnormalities associated in the localized area with the lesion which would evolve and worsen over time with continued exposure to coal mine dust. Additionally, he would expect changes in the left lobe lesion would occur closer to 1986 when Mr. M. was still working in the mines, rather than long after his coal mine employment ended.

Dr. McSharry testified that that he "would expect that there would be a fair amount of abnormality in the lung function if there was that sort of distortion of lungs going on because [of] coal dust exposure." Granulomas generally do not impair lung function. Dr. McSharry does not

think that Mr. M. has simple coal workers' pneumoconiosis or complicated pneumoconiosis or progressive massive fibrosis. However, if Mr. M. had simple coal workers' pneumoconiosis, Dr. McSharry would "concede the possibility" that some of the larger lesions that evolved over time could be related to that even though they are not typical of pneumoconiosis. None of the masses, neither the one in the left upper lobe nor the ones in the mid and lower lobes, are due to a chronic dust disease of the lungs. Dr. McSharry does not think that Mr. M. has any respiratory impairment and believes he could return to his last coal mining job based on his pulmonary system. If Mr. M. had never worked in the mines, he would still have the same x-ray abnormalities.

Discussion

Dr. Forehand concluded Mr. M. was totally disabled. Dr. Robinette diagnosed complicated pneumoconiosis. Dr. Hippensteel and Dr. McSharry opined Mr. M. was not totally disabled. To resolve this conflict in medical opinion, I must assess the relative probative value of each respective opinion in terms of documentation, reasoning, and treating physician status.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Third, according to 20 C.F.R. § 718.104(d), in evaluating medical opinion, an administrative law judge must consider the relationship between the claimant and any treating physician. Depending on the duration, frequency, and extent of the treatment, the opinion of a physician who provided treatment for pulmonary concerns may be entitled to more probative weight than the assessment of a non-treating physician.³⁴ At the same time, no presumption of greater probative weight exists merely based on a physician providing treatment. See *Consolidation Coal Co. v. Director, OWCP [Held]*, 314 F.3d 184 (4th Cir. 2002).

³⁴See *Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) (In light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician.)

With these principles in mind, I first note that as Mr. M.'s treating physician for more than 10 years, Dr. Robinette was well positioned to provide the most probative assessment. However, due to insufficient reasoning and inaccurate documentation, his opinion suffers a loss of probative weight. In terms of reasoning, Dr. Robinette never specifically opined that Mr. M. was totally disabled due to a respiratory impairment. The absence of that diagnosis is significant because his treatment notes presented conflicting evidence of an impairment. Specifically, although Dr. Robinette noted wheezing and diminished breath sounds upon physical examination, Mr. M.'s pulmonary function tests were normal and his oxygen saturation was 93%. Regarding documentation, Dr. Robinette based his diagnosis of progressive massive fibrosis and complicated pneumoconiosis, which as previously discussed would establish an irrebuttable presumption of total disability, on an inaccurate radiographic record. Dr. Robinette believed chest x-rays, in particular the large mass in Mr. M.'s upper left lung, established the presence of complicated pneumoconiosis. However, I have determined the preponderance of the radiographic evidence is actually negative for the presence of a large pulmonary opacity consistent with pneumoconiosis.

Similarly, Dr. Forehand's finding of total disability has diminished probative value due to documentation and reasoning shortfalls. First, Dr. Forehand relied on inaccurate documentation because he believed the radiographic evidence was positive for the presence of complicated pneumoconiosis when in actuality the preponderance of the radiographic record is negative for complicated pneumoconiosis. Second, Dr. Forehand concluded the presence of complicated pneumoconiosis caused serious and totally disabling damage to Mr. M.'s lungs. However, considering that the arterial blood gas study and pulmonary function tests conducted by Dr. Forehand were normal, the physician provided insufficient reasoning for his conclusion Mr. M. had suffered totally disabling lung damage.

Aware that Mr. M.'s last coal mine job involved heavy manual labor, and upon review of the entire record and his examination of Mr. M., Dr. Hippensteel presented a documented, reasoned, and probative conclusion that Mr. M. did not suffer a totally disabling pulmonary impairment. Based on the preponderance of radiographic evidence which did not establish the presence of complicated pneumoconiosis, and noting the pulmonary function tests and arterial blood gas studies were normal, Dr. Hippensteel reasonably concluded Mr. M. was not totally disabled. Dr. Hippensteel also explained that the most likely diagnosis of sarcoidosis produces varying pulmonary effects, which in Mr. M.'s case did not cause an adverse pulmonary impairment.

Based on the preponderance of the chest x-rays, which was negative for complicated pneumoconiosis, the normal pulmonary tests, and aware that Mr. M.'s last coal mine employment involved heavy manual labor, Dr. McSharry also presented a reasoned, documented, and probative conclusion that Mr. M. is not totally disabled from a pulmonary perspective, which is most consistent with all the medical evidence in the record.

In summary, due to the diminished probative value of Dr. Robinette's and Dr. Forehand's medical opinion, and in light of the probative consensus of Dr. Hippensteel and Dr. McSharry, Mr. M. is unable to establish total disability based on probative medical opinion under 20 C.F.R. § 718.204(b)(2)(iv).

Conclusion

To prevail in the initial consideration of his subsequent claim, Mr. M. needs to show that one of the previously denied conditions of entitlement, specifically total disability, is now present. However, the preponderance of the radiographic evidence is negative for complicated pneumoconiosis, the pulmonary function tests and arterial blood gas studies are normal, and the preponderance of the probative medical demonstrates Mr. M. is not totally disabled, such that Mr. M. is unable to establish total disability under 20 C.F.R. §§ 718.204(b)(2)(i)-(iv). Accordingly, under 20 C.F.R. § 725.309(d)(3), having failed to prove a requisite condition of entitlement previously adjudicated against him, Mr. M.'s present subsequent claim must be denied.

ORDER

The black lung disability claim of MR. J.M., Jr. is **DENIED**.

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: September 10, 2007
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties

Certification:

Richard Mullens, MD

Certified by the American Board of Radiology in:

Diagnostic Radiology

American Board of Medical Specialties

1007 Church Street, Suite 404

Evanston, IL 60201-5913

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